EXHIBIT 9
DATE 3-23-07
SB 417

U.S. Department of Justice

Antitrust Division

City Center Building
1401 H Street NW, Suite 4000
Washington, DC 20530
(202) 307-0001

December 8, 2006

Via FAX and U.S. Mail

South Carolina State Health Planning Committee
South Carolina Department of Health and Environmental Control
Division of Planning and Certification of Need
2600 Bull Street
Columbia, South Carolina 29201

Re: Draft 2007 South Carolina Health Plan

Dear Members of the Planning Committee:

In response to the request for public comments, we are writing to encourage you to consider the benefits of competitive entry into hospital markets in deciding whether to adopt the Draft 2007 South Carolina Health Plan ("2007 draft Plan"). While the Antitrust Division of the U.S. Department of Justice ("Antitrust Division") has not reviewed in detail all aspects of the 2007 draft Plan, we have identified two provisions of the 2007 draft Plan that address entry into hospital markets. Because state-erected barriers to entry pose a substantial threat to proper functioning of markets and could thereby harm South Carolina patients and other healthcare consumers, we offer these comments.

The 2007 draft Plan recognizes the value of competitive entry. As you may be aware, the Division has previously expressed concern that an interpretation of the existing 2005-2006 Plan would harm hospital markets in South Carolina by denying a certificate of need ("CON") to build a new hospital if the applicant was not currently operating in the state or operating in the county where it proposed to build the new hospital. The Antitrust Division believes that the 2007 draft Plan improves on the 2005-2006 Plan by making clear that "any entity" may apply to build new beds authorized by the Health Plan. *See* Page II-7(e) of the 2007 draft Plan. In this regard, the 2007 draft Plan protects South Carolinians by assuring them the opportunity to benefit from new hospital competition.

On the other hand, the 2007 draft Plan proposes a new restriction on competitive entry – a ban on all single-specialty hospitals obtaining a CON. *See* Page II-8(f). We are writing to highlight the substantial harm that may result from such a blanket ban on the entry of such hospitals.

During hearings conducted jointly by the Department of Justice and the Federal Trade Commission in 2003,[1] we obtained substantial evidence that vigorous competition among healthcare providers "promotes the delivery of high-quality, cost-effective healthcare."[2] Specifically, we reviewed evidence that the entry of single-specialty hospitals may "achieve better outcomes through increased volume, better disease management, and better clinical standards."[3] One potential competitive advantage of these hospitals is to increase the efficiency of physician services, such as surgical procedures, provided in the hospital setting.[4]

In the Report prepared after our hearing, both federal agencies advised state and local governments against using Certificate of Need authority to erect barriers to entry.[5] That recommendation was based in part on the ability of "market incumbents" to use the CON process "to forestall competitors from entering an incumbent's market."[6] The Report counsels particular caution when it comes to new, innovative forms of healthcare delivery such as single-specialty hospitals; indeed, we have received significant complaints that incumbent general acute care hospitals have used potentially anticompetitive tactics to resist the entry of single-specialty hospitals.[7] Creating a government barrier to entry will insulate your incumbent hospitals from additional competition, which could diminish the quality of care delivered to patients, as well as reduce the incentive of traditional community hospitals to improve service and reduce costs in reaction to competitive forces.

We are not aware of significant evidence that banning the entry of single-specialty hospitals creates benefits that outweigh those likely to flow from more competitive healthcare markets. Some of the persons who testified at our hearings expressed concern that single-specialty hospitals might reduce incumbent community hospitals' ability to use revenues earned from more profitable patients to fund care for less profitable patients. However, a later Medicare Payment Advisory Commission (MedPAC) Report examined this concern.[8] MedPAC made

---

[1] Improving Health Care: A Dose of Competition, ch. 3, § VIII (July 2004), available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

[2] Id., Executive Summary, at 4.

[3] Id., Executive Summary, at 15.

[4] Id., Chapter 3, at 19.

[5] Id., Executive Summary at 22.

[6] Id.

[7] Id., Chapter 3, at 22-23.

[8] Report to the Congress: Physician-Owned Specialty Hospitals Revisited (August 2006), available at http://www.medpac.gov/publications/congressional_reports/Aug06_specialtyhospital_mandated_report.pdf.

important findings that you may wish to study as you consider the 2007 draft Plan. Among them, MedPAC found that specialty hospitals did not undercut the financial well-being of rival community hospitals, which were able to offset the revenue losses attributable to specialty hospital entry, primarily by improving efficiency and expanding profitable lines of business; overall, community hospitals affected by specialty hospital entry maintained profit margins in line with national averages. Coincident with the release of the final MedPAC report, the United States Congress allowed its "moratorium" on the construction of specialty hospitals to expire.

In light of the potentially lost benefits from competitive entry of single-specialty hospitals, we urge you to consider whether the outright ban on their entry actually is justified by other social policy goals. We urge you to consider alternatives to banning completely such competitive entry when considering arguments on this issue.

We would be pleased to consult further with you on this issue or to address in more detail the issues raised in this comment.

Respectfully,

Mark J. Botti
Chief, Litigation I Section

Specialty Hospitals: Myths vs. Facts

MYTH: Specialty hospitals harm general hospitals.

FACTS: **There is no evidence that specialty hospitals harm general hospitals.** In fact, specialty hospitals have forced general hospitals to become more competitive. The Medicare Payment Advisory Commission (MedPAC) March 2005 report found that in the areas where physician owned specialty hospitals are located, general hospitals demonstrate financial performance comparable to other general hospitals. In addition, a February 2005 recent study by Health Economics Consulting Group found that general hospitals in areas with at least one specialty hospital actually have higher profit margins than those that do not compete with specialty hospitals.

MYTH: Physicians who invest in specialty hospitals where they refer patients create a conflict with the best interests of their patients.

FACTS: **Physician investment in and referral to specialty hospitals does not conflict with the best interests of patients.**

- Preliminary findings from a 2005 HHS study contained no evidence that physicians who have an investment interest in a specialty hospital inappropriately refer patients.
- In fact, the study showed no difference in referral patterns between physician investors and non-investor physicians regarding referrals to both general hospitals and specialty hospitals.
- MedPAC found that overall utilization rates in communities with specialty hospitals were similar to utilization rates in other communities.
- Physicians have an ethical and legal obligation to refer patients to the facility that best meets the needs of the individual patient.

MYTH: Physicians who invest in specialty hospitals "channel" patients to these hospitals.

FACTS: **General hospitals "channel" patients.** General hospitals:

- Adopt policies that force hospital staff physicians to only refer patients to their facilities,
- Purchase physician practices and direct the physicians to refer to the hospital,
- Operate health plans with network referral requirements.

When hospitals dictate where physicians may refer patients, the hospital takes medical decision-making away from physicians and patients. This limits patient choice and can conflict with the healthcare needs of the patient.

AMERICAN MEDICAL ASSOCIATION
April 2005

MYTH: Specialty hospitals exist because of a loophole in the physician self referral laws, the "Stark Laws," known as the "whole hospital exception."

FACTS: **Specialty hospitals do not exist because of a so-called legal "loophole."** It is both legal and ethical for physicians to invest in a hospital and refer patients there if they treat patients at that hospital. The hospital exception in the Stark Laws permits physicians to invest in and refer patients to a hospital if they treat patients at that hospital and the referral is to the "hospital itself" and "not merely in a subdivision of the hospital." **Specialty hospitals are <u>entire</u> hospitals, not subdivisions of hospitals.** They provide a wide range of services for patients from "beginning-to-end" of a course of treatment, including specialty and sub-specialty physician services, and a full range of ancillary services. Many specialty hospitals also provide primary care services and have intensive care units and emergency departments.

MYTH: General hospitals offer a full range of services that communities depend on in times of need—such as trauma care and burn units.

FACTS: **Though a number of general hospitals do offer such services, <u>the majority do not</u>.** The AHA identified 4816 short term, acute care general hospitals in 2002. According to the American Burn Association, there were approximately 131 burn units in the U.S., representing only **3% of U.S. hospitals**. According to the National Inventory of Hospital Trauma Centers, there were 1154 trauma centers in the U.S. in 2002, representing **less than 25% of U.S. hospitals**. Even fewer hospitals have Level I trauma centers (190) or Level II trauma centers (263).

MYTH: Physicians who invest in specialty hospitals will not serve "on-call" in the general hospital's emergency department.

FACT: **Physician ownership of specialty hospitals is not the reason that hospitals are facing on-call coverage problems.** On-call coverage problems result from numerous issues such as medical liability concerns, shortages of certain specialty physicians, unequal payment rates for on-call services, and the generally increasing demands on medical staff. Some general hospitals have actually exacerbated on-call coverage problems by adopting policies that alienate physicians—such as forcing physicians off of their medical staff if they invest in a specialty hospital. In sum, problems that hospitals are experiencing with on-call services to their emergency departments began long before general hospitals became concerned about specialty hospitals.

AMA to Congress: Specialty hospitals, competition promote high quality patient care

e-mail story | print story

AMA trustee calls for end to moratorium on physician referrals to specialty hospitals

For immediate release
March 8, 2005

WASHINGTON – Specialty hospitals provide quality care to patients, and the current moratorium on physician referrals to specialty hospitals should not be extended, the American Medical Association (AMA) testified to the House Ways and Means Health Subcommittee today.

"The AMA strongly supports and encourages competition as a means of promoting high-quality, cost-effective health care," said AMA Trustee William Plested, MD. "Patients should continue to benefit from these specialty hospitals."

A three-year study of MedCath, a chain of heart specialty hospitals, found that these hospitals cared for sicker patients than the local hospitals and had better outcomes. MedCath hospitals also treated more complex cardiac cases and had a higher proportion of patients undergo surgery compared to hospitals treating similar patients.

"Focusing on a specific area of service can lead to higher quality and lower costs as a result of more expert and efficient care," said Dr. Plested. "By performing high volumes of specific services, specialty hospitals can perfect those tasks, increase accountability for the quality of care provided to patients, lower fixed costs and quickly respond to patient needs."

While general hospitals have expressed concerns about competing with specialty hospitals, there is no data that physician ownership and referrals to specialty hospitals conflicts with the best interests of their patients.

"Competition works," said Dr. Plested. "In the hospital industry, the addition of specialty hospitals to the mix gives patients more choice, forcing existing hospitals to innovate to keep patients coming to them. This is a win-win situation in providing a better quality of care."

"This does not need to be an either-or scenario. Support for physician-owned specialty hospitals in no way diminishes the important role of the general hospital in the community," said Dr. Plested.

General hospitals should be appropriately paid for the community services they provide to eliminate reliance on higher paying services to subsidize community care. "The answer is to support competition and eliminate cross-subsidization of services," said Dr. Plested.

###

For additional information, please contact:

Katherine M. Hatwell
Public Information Officer
AMA Media Relations
(202) 789-74[illegible]

Last updated: Jan 04, 2006
Content provided by: Media Relations